SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
Rehabilitation Supports

NOTICE OF TERMINATION

Please Type or Print

(Must be completed within two days of termination)

Person's Name:	
Address: City:	State:
Zip:	Social Security Number:
Medicaid #:	
The person is no longer eligible to receive Rehabilitation Supports for the reason below:	
☐ Death	☐ Voluntary withdrawal
☐ No longer needs Rehabilitation Supports	☐ Has not received a service for two (2) consecutive calendar months
☐ No longer meets eligibility requirements (Explain):	
EFFECTIVE DATE OF TERMINATION: ____/ ____/ _____ *(Must be completed)*	
As a result of this termination, the services and activities, which are currently provided and funded through Rehabilitation Supports, will no longer be funded in this manner. ☐ Individual Rehabilitation Supports ☐ Facility Based Rehabilitation Supports	
Rehabilitation Supports Lead Clinical Staff Name:	
Provider:	
Address:	
Phone:	

Signature:_____ Date:_____
Lead Clinical Staff

Original: ☐Recipient/Family Copy: ☐ Service Coordinator / Early Interventionist & Person's Record Copy: ☐DDSN Finance Division

RS Form 6 (1 of2)